Nursing Homes

OFFICIAL JOURNAL - AMERICAN NURSING HOME ASSOCIATION

In This Issue:

New Growth For New Strength

What I Saw In Europe

VOL. 10, NO. 1 JANUARY, 1961

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An appeal from ANHA Membership Chairman Eldred Thomas:

NEW GROWTH FOR NEW STRENGTH

There is strength in unity, and strength in numbers. Both these factors are very important to any truly *national* organization. They are certainly of importance to *us*.

In order to retain and bolster that strength, the American Nursing Home Association is embarking upon its biggest membership drive ever. It will be a well-organized, concerted drive — it will have steam and strength behind it — it will be nationwide.

But any such effort will fail unless not only the officers but also the membership of the organization stand behind it, direct it and push it on to victory. This is what we aim to do.

How are we going to go about it?

Various concrete steps will be taken. Each one of them will be part and parcel of the overall campaign. In effect, the first of these steps has already been taken. During the past two weeks, at the request of our national officers, state presidents began to mail out a statement to members of their state associations showing the amount due for membership in both the state and American Nursing Home Association for 1961.

In mid-January, a second such mailing hit mail boxes of members and non-members alike. It reminded both groups that membership dues were payable—*now*—and to forward the amount quickly.

Mailing number three is scheduled to be sent out by February 1. Its purpose is not only a dues-reminder, but to explain and stress the objectives of our state associations in 1961. Its purpose, too, will be a hard hitting appeal to non-members to join—and join *now*.

Yet another such statement will arrive in nursing homes about the middle of February. It, too, will have a special and important reason: It will be intended to fortify the reasoning behind an appeal for nursing home administrators to join us. It will once again explain the cogent reasons and strong advantages of becoming members in the state and national groups. It will incidently also include another reminder of membership dues.

Why this four-fold effort?

We believe that the years ahead are years of great and important decisions for our profession. We believe that the years ahead will be trying but also successful years. We believe that during those years we will accomplish much—but to accomplish much demands the largest possible representation of everybody in this profession in our common cause.

Therefore, every effort will be put forth to strengthen and increase our membership — to associate with us all those who have a common interest in this, our profession. To reach this important goal, we shall not rest until we have accomplished what we have set out to do: to gather in the largest possible number of eligible nursing home administrators.

This task will not be a simple one. It will demand an extra effort on the part of every state and national officer in our association, and it will also demand the fullest cooperation of the rank and file of our membership.

We need you—we need your help —we need your biggest membership recruiting effort ever put forth. If we succeed in our membership goal, we will have taken a large step in the direction of accomplishing the urgently important goals which we have set for ourselves.

That is why this membership campaign must succeed because, as we said at the beginning, there is strength in unity and strength in numbers. Both these factors are very important to any truly *national* organization. They are certainly of importance to *us*.

Or, quote the words of ANHA Secretary and Membership Chairman Eldred Thomas as stated in his new membership drive brochure: "The ANHA marches forward through cooperation, representation, and organized strength. Our voice can be heard, our *goals* can be met, if the *majority* of Nursing Homes in America are members of ANHA.

"Results will be forthcoming, if *each* state adopts this, or a similar membership drive, and begins immediately and *actively* promotes, supports, and gets this effort to rolling."

Reward for Growth

At the 1961 ANHA convention in Cleveland, Mrs. Alton Barlow, wife of ANHA's president, will present a three hundred fifty dollar Silver Service (see cover) to the state which has had during the year the greatest increase in membership percentage-wise. This beautiful Service will be contributed to the association as an annual membership award by Mrs. Alton Barlow. The award itself will be kept by the winning state for one year. However, should any state win it three years in succession, it will remain in that state's possession.

President Barlow will also make an award at the Cleveland Convention; namely, to the state which has had during the year the greatest increase in the number of members.

A 'hot' topic is hot news in Oklahoma:

Classification is on the Way

By JACK PROPPS
ANHA Regional Vice President, Region 7

Classification is a topic which will be heard and discussed more and more wherever nursing home administrators meet. That's why the following story, reprinted from the Oklahoma Nursing Home News, is of topical significance to all who 'care.'

What is Classification? It is a voluntary program of self-appraisal that is being conducted by the Oklahoma State Nursing Home Association.

The Oklahoma State Nursing Home Association has recognized the need of such a program, but since the association was quite small in its early years of existence, consisting only of a few agressive home owners, the project of classifying 500 licensed facilities was too great an undertaking at that time. Not until three years ago did we feel we were large enough to adequately undertake such a program. Thus we began to take a realistic view of the mechanics required to conduct a fair and complete survey of the nursing homes in the state.

Three years have been spent in preparation. Many committee meetings were held on the part of a great number of association members who gladly gave their time to bring about classification. We now have policies and procedures and a classification form by which a nursing home can be successfully evaluated.

Through this program of classification we can now reflect the quality of care and the value of that care to our communities, medical profession and other interested parties. We can dispell the public opinion that all nursing homes are alike. Classification is somewhat like the Hospital Accrediation program. Nursing homes that are classified can compare their services with the other 500 homes in Oklahoma and through this comparison know if they have room for improvement and in what part of this services this improvement is needed.

Classification is not a licensure program. It takes over where the licensing program leaves off. We wish to show the services over and beyond the minimum requirements that are being given. The scoring report has seven parts: Physical Setting, Medical Information, Charts, Records, etc. Liaison With Other Groups, Diversional Activities Provided for the Patient. Our scoring is based on 1,000 points, broken down into three groups "A" Group, 750 to 1,000 points, "B" Group 500 to 750 points and "C" Group, less than 500 points.

In order to participate in this program, applications must be currently licensed and comply with the minimum standards of the licensing program of the State of Oklahoma. *Inspection will only be made upon written consent and request of the nursing home administrator, and accompanied by the classification fee. Re-Classification will be done on an annual basis dated one year from the date of the previous classification.*

Each time a new request must be made, although the classification committee shall have the authority to make unscheduled inspections of any facility participating in classification to ascertain that the standards are being maintained.

WHY BE CLASSIFIED?

This question will probably be asked by a great number of people who have not kept current with our classification efforts for the past three years. Most of the states in the eastern part of the United States have had a program of this type for quite some time and have used their findings to many advantages. A few states are now receiving Blue Cross and other insurance payments for some of their patient care. This was done by classification. Welfare rates have been adjusted from year to year on a realistic basis to meet the increased cost of giving nursing home care.

The director of our welfare program, has stated that there will be no more raises to all homes across the board, only on a classification basis to homes that are giving services that warrant such raises. The cost of classification is $100.00 for association members and $150.00 for non-members. This may seem a little high, but if you figure that it requires a great deal of travel, secretarial services, office supplies, rechecking and etc., you can see that it is reasonable.

The reason for the difference in association members and non-members is that the association has been paying the expenses for years for non-members legislative benefits, national and local, for promoting good laws, fighting poor legislation, for nursing aide training programs, study clinics and many many other services not to mention the expense of the last three years in preparing for classification. *As this is a program for all homes, members or not, we feel that each should pay his own way.*

CLASSIFICATION PROGRESS

Our program to classify the homes of Oklahoma got underway with the first home to be classified located in Oklahoma City. This was done on July 6, 1960. The Belle Isle Nursing Home is to be congratulated for taking the lead in this historical program. The Belle Isle Nursing Home on our survey showed a well organized home with patients receiving exceptionally good care.

To date, September 5th, there have been thirty-six homes classified. This is a wonderful response, considering that these homes represent 1,065 beds of our total licensed beds of Oklahoma. The homes we have classified are as small as nine beds and as large as 100 beds.

The reception our classifying teams are receiving when we enter the homes that are to be classified has been taken with good will. The classification reports have been lower than expected by some nursing home administrators, yet they have accepted this with no complaint and have stated that they could now improve where they are falling short.

We gave association members the first 60 days to be classified as they are the ones who have made this program possible. Beginning the first of September this program was opened up to all licensed homes.

Frank C. Bateman

FRANK-LY SPEAKING

Membership being the primary goal for 1961, we quote from a recent article on "Free Riders" by Mr. John W. Mock, nationally known figure in association circles. Mr. Mock in writing in the September issue of the **Retail Coalman** placed strong emphasis on association membership and the "Free Rider". Mr Mock stated, "Personally, during fifteen years of working with several hundred top professional, trade and civic associations and service clubs, I have never found a single man who wanted, really wanted, to be a Free Rider, or would even consider himself a Free Rider. I have known non-members, while enjoying many of the blessings of their industry's Association's efforts, to justify their refusal-to-join in many ways. Warden Lawes, when head of Sing Sing, declared that he never knew a criminal who considered his crime, or crimes, as unjustified. The same principle applies to the Free Rider!

The first question that must be answered is, "Down deep, are you sure that your Association is furnishing **valuable services** to your members?

"There are many types of Free Riders. Keep in mind, please, that it's you that consider them Free Riders, but they do not accept this classification. There is the serious, misguided individual who is still living dreamily in the Age of Rugged Individualism. He cannot be sold a membership until he is convinced that this is the Age of Organization and cooperative effort for the common good of the industry. Today, as never before, 'No man is an island,' but until you achieve agreement on this point, this type of Free Rider is a conscientious objector in his own esteem, untouched by any guilt complexes.

"Again, you've met **the avowed skeptic,** who forcefully says he thinks that every Association is controlled by clique-domination for the advantage of the few rather than for the good of all. Top Executive clients have assured me that the best way to blast this alibi is to promise the complainant that, immediately upon joining, he will be placed on the particular committee or committees he suspects of malfeasance so he can take steps to correct the situation. This 'put-up-or-shut-up' technique has the obvious merit of spotlighting the insincere objector. An insincere, opportunistic member is never an asset, is he?

"Of course, always with us is the irritating chap who is sore at the Association because nobody has made a fuss over him. With this type, I have observed, an officer of the Association is the most **effective salesman.**

"One of the most aggravating Free Riders, and among the most difficult to sell, is the little boy who never grew up. You know the type. Everyone thought it was 'so cute of Egbert' when he sneaked under the circus tent even though he had the ticket-money in his pocket. He still considers himself 'cute,' and is always trying to earn the description by still sneaking under tents without paying. This type of Free Rider is the one possible exception that will acknowledge that he is a Free Rider — and proud of it. He will not accept the indisputable economic law that applies to all adults: 'There is no such thing as a free meal.' Such 'poppycock' only serves to whet his appetite for more opportunities to establish his 'cuteness,' which he confuses with acumen. My advice to you on how to handle this Jolly Boy is the same given to me many times during the depression by my Sales Manager: 'Better get yourself another prospect!'

"The last of the Free Riders I am going to investigate with you is the emotional misfit who is far better for the Association as a Free-Rider than as a Trouble-Maker. This type is represented by the centenarian who was asked by a big-city reporter on his 100th birthday, 'I'll bet you've seen a lot of changes in your lifetime, eh, Dad?', to which the Aged One replied proudly, 'Yup. Sure have. And I've been agin every durn one of 'em!' These 'agin-ers,' who are consistently negative, cannot help any progressive Association. It is one thing to

(Continued on page 12)

As we write these lines, 1961 is still a youngster. But already it includes some important events. Among these is the *White House Conference on Aging* held early this month. And, of course, there is a new President of the United States in the White House along with a brand-new cabinet and Congress.

There is a new look, too, in our own Association. *President Alton Barlow* and his "cabinet" took office officially on January 1. This column wishes him and his fellow officers of the American Nursing Home Association the best of luck. That goes, too, for all Regional Vice Presidents and other officers on the national, state and local levels.

Dr. Bruce Underwood, who writes the popular "If You Ask Me" column in this magazine, is going to address the Arizona Association of Nursing Homes, Inc. later this month (January 26). The title of his talk: "Trends in the Nursing Home Field." If there is anyone among you who doesn't know it, Dr. Underwood is Chief, Nursing Home Services Section, Chronic Disease Program, Division of Special Health Services, Department of Health, Education, and Welfare. Wish we could listen in!

Time, space and deadlines were made to plague editors. All three of them combined to prevent our mentioning in an earlier issue the Wyoming Licensed Nursing Home Association Work Shop which was held at Thermopolis, Wyoming recently. Thanks to Beulah Bushmaker who sent us a program, we notice two topics in particular that sound interesting to us: "The Mental Processes of Aging," and "How to Keep the Hands and Minds of Your Patients Occupied." Thanks for thinking of us, Beulah.

The future of our profession is up to us — all of us. In that connection, we hasten to report that a *Membership Campaign brochure* is in preparation. It will give you valuable hints on how to go about obtaining new members. But no amount of how-to-aid can substitute for each member's enthusiasm for the cause of association solidarity — and growth.

We recently reported about the promising progress of our *exhibit space sales* for the October 1961 convention. We can now report even better news: more than half of the spaces have been sold. Good news? Terrific news, as we see it. But — will you be there — in Cleveland — to see those exhibits? Think about it, plan for it . . . NOW.

We are glad to remind you that the new year may also bring you *a trip to Europe*. Pearl Dawson, head of the ANHA public relations committee, and Caroline Belcher, dreamed up the idea (and a thrilling idea it is, it seems to us) of creating a special tour for nursing home administrators. The major purpose: to tour European care-of-the aging facilities. (That this can be quite an experience, is attested by a story "What I Saw in Europe" written by our good friend, Kathryn Vaskov, president of the New Mexico Association of Nursing Homes, Inc. You will find the story elsewhere in this issue.)

Costs will be around $800 per person. This will include transportation, tours, hotel accommodations, tips, and most meals. And just to make sure that everybody knows you've been in Europe, a photographer-writer team will send back a flood of publicity back to your home town papers and radio-TV stations. Stopovers will include London, Oslo, Stockholm, Copenhagen — and also may take in Frankfort, Geneva, and Paris.

Why not fill in the coupon printed on this page — NOW? Here, as always, it's: first come, first served. So, let's hear from you!

Fill in and turn into headquarters, American Nursing Home Association, 1346 Connecticut Ave., Washington, D.C.

I am interested in making the 1961 ANHA chartered tour to Europe. Please keep me informed.

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NOTE: According to charter laws, only members of ANHA and their immediate families may fly at these rates.

Nursing Homes

OFFICIAL JOURNAL - AMERICAN NURSING HOME ASSOCIATION

IN THIS ISSUE

COVER PICTURE:

Oneida silver service donated by Mrs. Alton E. Barlow as the grand prize on membership

To all our readers
the best of everything for 1961

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An Administrator reports on :

What I Saw In Europe

By Kathryn Vaskov
President, New Mexico
Nursing Home Association

It's an interesting experience to tour Europe just to see the usual attractions that entice the usual tourist. But it's even more interesting to compare the standards of various countries with our own — be it in living conditions, business opportunities or, as is the case related in this report, in the operation of nursing homes.

As owner-administrator of a nursing home in Las Cruces, New Mexico, I was fascinated by some of the things I saw during my recent visit to nursing homes in several countries on the continent.

Of course, it was rather difficult to get detailed information on each home visited and impossible to visit all nursing homes in any given area. But my itinerary did enable me to visit some of the nicest and largest homes in many cities. Although I am able to converse in three languages it was difficult to make a complete survey in any but the larger homes where English was spoken.

Several countries, such as France, Belgium, the Netherlands, and Austria, are not included in the survey due to the limited amount of time I was able to spend in each of them. And in some instances, appointments were not properly arranged through the proper authorities and no one was on hand to show me through the home.

YUGOSLAVIA

I was born in Beograd, Yugoslavia, and I revisited that country, spending the month of August touring it and visiting a number of homes in the cities of Zagreb, Beograd, Opatija, Rijeka, and outlying villages and townships. I learned that there are no proprietary homes in Yugoslavia just as there is little private enterprise in other types of business due to its communistic form of government. Most nursing homes are served by a religious order and all homes are government controlled. The capacity of the homes I visited numbered from 35 to more than 400 beds in a single establishment. There are a few homes which cater exclusively to the chronically ill and aged but in most cases the type of patient cared for in the larger homes is ambulatory.

The national licensing agency is the state but since there is no national listing of homes available the number of homes in operation in Yugoslavia is unknown. There is no national nursing home association in Yugoslavia.

There is no set age limit on patients admitted to homes but a close approximation on the average would be 80 years. The ratio of patients to employees is about 4 to 1 which includes nurses, nursing aides, kitchen, laundry and maintenance workers but does not include managers or doctors.

How they Operate. In almost all homes the nursing is supervised by nuns or sisters. In almost all homes the laundry is taken care of on the premises. Food is supplied by the home through various means: Some homes have their own farms which supply the necessary beef, pork, chicken, eggs, and milk. Vegetables are home grown and canned in the homes. Other food programs consist of government supplements and allotments from such organizations as the United States Care Program. The dietary program is sanitary, refrigeration is available, and patients are well fed.

Salaries for employees of homes in Yugoslavia are poor by our standards but are average for the working class in that country. The average salary for a head nurse is about $35.00 per month; other employees receive about $9.00 per month. Cost for nursing care in Yugoslavia averages about 75c per day, and in all cases payments are made by the government direct to the home.

Home and Country. Rehabilitation is considered unnecessary in Yugoslavia and most homes do not offer any programs of this sort. Some of

Kathryn Vaskov, Hans Hohn (Director Altersheim) and his assistant, Nursing Home, Mainz, Germany.

the smaller homes have a type of rehabilitation program set up for certain cases but these do not apply to our standards. Recreational programs consist entirely of group visits, although in Yugoslavia the community takes little or no interest in the home or its patients.

Special nursing services such as I.V., Oxygen therapy, catheterization, sterilization, etc., is offered through the services of the physician only. The physician is assigned to the home by the state and the visits to patients are frequent. All services by doctors and dentists are free to patients and the doctors are paid a monthly salary by the state.

Conditions of the homes can best be described as fair to poor by American standards in construction and maintenance. Bathing facilities are extremely poor in all the homes I visited.

GERMANY

In almost extreme contrast to those in Yugoslavia are the nursing homes in Germany. Here the program for the care of the aging is similar to that of the United States. There are homes in Germany which are privately owned and operated as well as state, non-profit, and church sponsored homes. But there is no national nursing home association.

A German Home. A typical example of a non-profit governmental type of nursing home is the Malnzer Altersheim in Mainz, Germany. This home is controlled by a board of directors, has a 500 bed capacity, and has a waiting list of about 400. It is associated and operates in connection with a hospital and is licensed by the state.

The types of patients admitted are ambulatory and chronically ill, with an average age of 70, although young people with chronic disorders are also cared for. Some patients in the home are looked after by their own personal physicians, but 2 house physicians are available for all patients.

Nursing service is both general and special. There are 26 registered nurses employed during the day and 6 at night. There are no practical nurses but there are 40 nursing aides, 2 cooks, and 5 kitchen helpers. The maintenance crew consists of a workmaster, electrician, carpenter, 2 furnace men, 3 door men, a lock smith, and a gardner. Employees are offered room and board in addition to their salaries. Patient laundry is done in the home and the washing and ironing is taken care of by 9 employees. One sister and 3 helpers mend clothes and linen.

Nurses that are members of the Vencentiona Healing Order receive small salaries ($24.00 per month) compared to the nurses who are not with the order ($95.00 per month). Nurses on the night shift receive $5.00 per night if they have passed the state examination and only $4.50 per night if they have not.

The sick ward which is looked after by 2 nurses has a capacity of 45 beds. All nursing personnel is trained and qualified for the work.

Special nursing services offered are I.V., I.M., catheterization, and sterilization. No oxygen therapy is available.

Special diets are offered and the kitchen is very modern and efficient. The home has recreation rooms and equipment, television, radio, and rehabilitation programs. The patients receive occupational therapy and physical therapy on doctor's orders only.

Nursing charts are kept on acute nursing cases only. Records on admittance, diagnosis, discharge, death, and drugs are kept on all patients. Drugs are closely controlled and accounted for.

The home is newly-built, maintenance is good, and safety precautions are taken. There are private and semi-private rooms but no wards.

The relationship of the home with doctors, hospitals, and the community is very good.

In reference to financing patient care we find that 50% of patients in this home are self-supporting and the other 50% receive matched funds to cover the expense. Of these 250 who receive matched funds for the payment of their care some have no private income at all and must rely wholly on the state for their support. Such payment is made monthly.

Rates for ambulatory patients in a private room are $1.90 per day, in a semi-private room $1.45 per day, and for nursing cases the rates are from $1.67 per day and up. Medications are not included in these rates. The cost for medications per patient amounts to approximately $71.50 per month. Relief patients receive $5.95 spending money each month.

The city of Mainz, incidentally, is planning a new Old Folks Home with 200 beds in the near future. There are currently 17 private nursing homes in Mainz representing about 1200 beds.

ITALY

Homes in Italy are of several types also — governmental or state operated, church sponsored, and proprietary. I spent some time in Rome and visited the Pio Istituto dell' Addolorata, a non-profit home operated by a Catholic order of nuns under the supervision of the state.

The Pio Istituto dell' Addolorata receives the services of 4 physicians and has a staff of 20 nuns as nurses, and 65 aides — girls from the outlying villages and towns who receive their room and board and a small salary for their services.

Italian nursing homes are licensed by the state sanitation department.

Records are kept by the doctor on nursing procedures, diagnosis, and drugs. Other records on admittance, discharge and deaths are kept by the sisters. Drugs are controlled here also. Special nursing services are part of the physician's services. Nurses are allowed to give intramuscular injections only.

The handling and preparation of food is done by the sisters and the administrator buys all supplies and food. One sister is in charge of the kitchen and cooking and she has 5 helpers. Laundry is done in the home by 5 workers.

Recreation consists of Television and reading. There are rooms provided for these activities. No rehabilitation programs are offered but there is some occupational therapy.

Facts and Figures. The building which houses these patients is old and has been remodeled to meet the needs of the program. It is kept up by its maintenance crew and gives an overall appearance of orderliness. No private or semi-private rooms are offered at the Pio Istituto dell' Addolorata and the wards contain from 8 to 10 beds.

The relationship of the home to doctors and hospitals is very good

(Continued on page 16)

Re-Awakening Interests

By ROBERT N. BUTLER, M.D.

The following was presented in the symposium on "Improving Patient Care in Nursing Homes," sponsored by the Maryland Nursing Home Association, District No. 2, Maryland Nurses' Association, District No. 5, Montgomery County Tuberculosis and Heart Association, Montgomery County Health Department. Its subject matter is of urgent and immediate interest to all who care for the aged.

The Title. "Re-awakening Interests" is quite suitable for the comments I have to make here with one important qualification. We cannot afford to hold to the overdone and only partially accurate view that "the aged" (as a group) are helpless, passive victims of human disregard and devastating illness. This view or stereotype suggests that "the aged" are malleable to our ministrations, require and depend on them, and will otherwise wither away.

As I will sketch later, *it is not totally our function as therapists, nurses, etc., to re-awaken interests; it is also the function of the older person and patient himself.* I would refer you to the excellent, witty and spicy novel "Memento Mori" by the English authoress, Muriel Spark. Nearly all of the characters of this book are at least seventy or above and they are very much alive — including those who reside in an English geriatric ward, which is described in both an hilarious and macabre manner.

A New Look at the Aged

The phrase, Re-awakening Interests, has other connotations for me. There has been a recent re-awakening of interests in the aged on the part of medical and nursing personnel, activities therapists, scientists, governmental and elective officials. It is to be noted that this re-awakening is usually explained as a result of the rapidly increasing aged population and the consequent social-economic effects. I would like to show there are other excellent reasons for re-awakening our interests in the aged irrespective of their "population explosion" and independent of the social, economic and cultural climate of our times.

ABOUT THE AUTHOR

Robert N. Butler, M. D., received his B. A. degree from Columbia College in 1949, and his M.D. from the Columbia College of Physicians and Surgeons in 1953. He received his psychiatric training at the University of California, National Institute of Mental Health, Chestnut Lodge, and Washington Psychoanalythic Institute. At 34, he holds the positions of Research Psychiatrist, Laboratory of Clinical Science, National Institute of Mental Health with which he first became connected in 1955; Consultant Geriatric Unit Chestnut Lodge, Rockville, Maryland; and, since 1959, member of the Visiting Faculty, Washington School of Psychiatry. His numerous publications include several on the problems of the aged, in which he has for some time taken a particular interest.

Help from the Aged. The aged are a rich source of ideas about life. The final psychological development of man is largely ignored by contemporary personality theory. The study of those who have attended the final period of life in terms of survivors should enlarge our everyday concepts of stress and defense. The meanings of death, of time, of self-perceived bodily and mental changes, of losses and of grief, of loneliness, and of isolation, are among the "themes" about which the aged are particularly experienced — but which are also relevant to the experience of our younger patients. The study of the aged provides information concerning the natural history of personality and its deviations; the fate of neurosis, e.g., is a curious and interesting study in itself. The study of the older patient offers special insights into family life, its structure and development. By talking and listening to the older person we ourselves can gain insights into social history, the evolution of manners, etiquette, and mores. I shall return to the idea of *listening* later, for I believe one of the greatest difficulties the younger person experiences working with the aged is that of *listening*. The older person is "living in the past," garrulous, rigid, and demanding — *or so we feel him to be.*

More Knowledge Needed. . We know very little about the psychological aspects of the aged and the best that we know is to be found in the non-scientific literature, particularly the creations of novelists, essayists, and playwrights. Yet, paradoxically, we know a good deal and have increasingly available newer techniques of evaluation in therapy. *But what we know is not widely applied.* Thus, for example, insofar as the mental disorders of the aged are concerned, the hospitalized aged continue to be relegated to custodial care; and the community residents emotionally disturbed continue to be rarely seen by the psychiatrist. When we come later to reviewing several of the countertransference and/or cultural attitudes that have been identified, we will have at least some explanation for this failure to acquire knowledge and for the general despair that is prevalent.

The Problem of "Senility"

As you know, a very considerable percentage (probably up to 70%) of nursing home residents have apparent disordered mental functions. In our country it has been the custom to classify these changes as "senile" and to consider these as irreversible and untreatable. In England, on the other hand, it is more usual that depressions are recognized. In other words, many of our so-called senile cases represent persons in various states of depression and despair which are not always easy to distinguish from the latter.

I realize that the undertaking of evaluation is not current, however desirable, and I realize, too, that such a large scale undertaking is not likely to come about in the near future. Nonetheless, it is important that we be aware of the high incidence of these depressive states and that we each seek to increase our own ability to recognize them. The patient is benefited the moment it is clear to him that you are interested in his mood and in his life situation, and that you do not simply and categorically pigeonhole him as a senile. In the ideal situation, of course, appropriate evaluation is indicated and,

(Continued on page 8A)

Sun-sweetened, plump and juicy, Sexton yellow cling peaches are tenderly picked, carefully pitted and packed in halves, sliced or diced, in a full range of sizes. They are wonderfully versatile and economical, require little or no preparation for an almost infinite variety of savory salads and delicious desserts. Their piquant flavor is actually enhanced when you serve them hot with meat, fowl or fish.

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Re-Awakening Interests

(Continued from page 8)

needless to say, adequate evaluation must always precede adequate treatment. I hope our nursing homes will come to have increasingly more medical and psychiatric services.

I have no prescription to offer which will serve to re-awaken interests in our older patients. There are skills and techniques which we may use as necessary preliminary steps to activate; e.g., techniques to avoid contractures, etc. However, such techniques do not of themselves activate patients, foster self care, etc. Of course, in the course of carrying out such care, the patient may show a spark of response to the interest shown. But he may also respond by increasing his demands, by increased stubborness, etc.

Aspects of "Re-Awakening"

I shall turn, then, to the interpersonal and psychological aspects of the problem of re-awakening interests and not dwell upon particular procedures or techniques. I shall provide some of our observations derived from developing a unit at Chestnut Lodge, established to provide diagnostic services and an intensive psychotherapeutic inpatient program for the psychiatric disorders of the aged. First, I will take up two factors which affected the transformation from a medical nursing, custodial care program to a psychotherapeutically oriented one.

1. The Use of Age as a Defense: One of the major factors which appeared to affect the transformation was the observed occurrence of the phenomenon called here the use of age as a defense. One of the earliest clues to the existence of this phenomenon was the recognition of the discrepancy between the actual capacities of the aged patient and the way in which others, as well as the aged themselves, estimated them.

This phenomenon was characterized by the development of a mutual relationship between certain aged patients and certain staff members in which "the idea" of age and its accompaniments eventuated in confusion as to responsibility for decision-making and personal care. Of diverse origin, the adaptation favored denial rather than insight and was marked by cyclical periods of mutual protection augmented by guilt and mutual rage. This situation was unexpectedly pervasive and not related to a few individuals. All of the staff, including the psychiatrists, nurses, activities therapists, the psychiatric social worker, and the internist, participated in this adaptation at various times.

In the initial phase of the cycle the patient would find his request met by the staff member who responded in part to the patient's age. But as requests increased, the staff member began to perceive the requests as demands and his responses would either decrease or be accompanied by annoyance, usually indirect at the beginning. As time passed, the patient would experience and demonstrate increased rage and outrage at the failure of the staff members to take proper care of him, ("No one cares about an old man," etc.). Concurrently, the staff member would become enraged and outraged at the "demandingness" of the patient. Eventually an overt explosion would occur during and after which both participants would feel anxiety and guilt.

For example, the patient might say, "The nurse is too overloaded with work," and the staff member, "He is an old man, after all." Renewed friendliness would follow marking the beginning of a new cycle. A further characteristic would be the mutual protection of the participants made obvious when a nonparticipant would intervene, whether the intervention prompted the explosion or occurred in any other point in the cycle.

Both cultural and personal determinants appeared to be involved in this kind of situation. Some of its ramifications are taken up again below. A paper is in preparation where this phenomenon will be more fully characterized and clinical examples given in full. It will suffice here to provide some instances of this phenomenon. In the course of this program many questions arose as to the specific capacities, mental and physical, of the aged patients to participate in various activities. There was a distinct and unfortunate tendency, however, to underestimate capacities and not to determine them by actual experience. There were many concerns for the patient that might range from his physical limitations to the effects of the weather, all of which could have the effect of limiting his activity. Also, protectiveness was observed; for example, frightened, overwhelmed spouses were encouraged to stay away from the hospital by the clinical administrator or the social worker and to look after themselves. As a consequence, communication between the patient and the spouse was reduced and decisions requiring their mutual participation were avoided.

The Aged are People. In society at large, the aged have been singled out as a special class. This singularization is seen in the remarkable number of expressions (for example, "golden age," "senior citizen," and the like) that have been invented as well as in the fixed stereotyped ideas held about the aged. Because of chronological age, the category, "The Aged," tends to be seen as homogeneous rather than as composed of dissimilar and varied persons of diverse capacities aging at different rates. In fact, the degree to which chronological age per se *is* the overriding factor in the disorders of the aging is now in serious question. The significance of other factors, including personality, psycho-social destructions and losses, diseases and the like, is becoming increasingly clear, as we have been finding in analyzing our 5-year multidisciplinary project on aging at NIMH. (*Human Aging: Bilogical and Behavioral Aspects.* Eds. Birrens, J., Butler, R.N., Greenhouse, S., Perlin, S., Sokoloff, L., and Yarrow, M.).

The aged, in turn, consciously and unconsciously provoke protective responses. Here it was observed that several accepted and promoted their helplessness, and expected near-total nursing care which they usually received. Nearly all the original custodial group were considered to "require" considerable nursing care, the provision of which did not relate approximately to need. At the same time, the aged themselves are often made anxious by this. When his requests are not met by a person he trusts, he may feel reassured about his own capacities. If these requests are met, his own concerns are often reinforced.

The use of drugs illustrates this, I think, exceptionally well. When a psycho-pharmacologic agent is in-

troduced, the rationale for its introduction and its meaning to the patient should be made clear. Many oldsters feel that, as they will put it, their "minds are slipping," or that they are, as they might also put it, "too disturbed to get along without sedation." Administration of sedation may then indicate concurrence on the part of the administrator of the medication with the latter view and also provide concrete evidence for the former by way of the definitive cognitive and perceptual effects induced by the drug itself.

One consequence of observing the phenomenon described was the administrative decision to avoid special equipment which emphasize age and limitations. It was decided, for example, not to obtain one of the ultra-modern devices available for the bathing of the aged. This device was not missed. Another consequence was the decision that the mental and physical capacities should be tested if not always by more precise medical and psychological tests, at least, and probably especially, by experience. Ultimately, of course, the basis of the phenomenon needs to be explored with the participants on each occasion of its occurrence. Certainly, any serious attempt to conduct an insight-producing psychotherapeutic milieu and to utilize its major instrument, individual psychotherapy, requires recognition of the occurrence of this phenomenon. This holds for attempts to foster self care and activation.

2. Countertransference or Cultural Attitudes:

The second category of phenomena that I want to mention are certain cultural or countertransference (personal) attitudes about the aged that have revealed themselves in connection with psychotherapy. It was clear that much would be learned about our attitudes concerning the aged by observing the psychotherapeutic process.

Several factors will be indicated here: First, the extraordinary emphasis on the limiting factor of organic loss. Some personnel, including therapists, seemed unduly impressed by the cognitive losses that occurred with age. To a degree, it is fair to say that the majority of research throughout our country with respect to the aged has had to do with an almost enthusiastic measuring of decline in various functions. Comparable attention toward studies of individualization of the aged, of wisdom, of the meaning of experience, and the like, are not ordinarily found. To some extent, this may reflect a cultural bias towards rational man, such that reasoning, memory, and the like, are considered the most important parts of a person. It is also probable that certain personal and often idiosyncratic attitudes are prominent here or reinforced, the idea of the older person as unconsciously equated with the parent, no longer standing as the wise, advising, reasoning figure, would be expected to effect each of us as therapists and staff members differently in accord with our own residual dependence upon the parent.

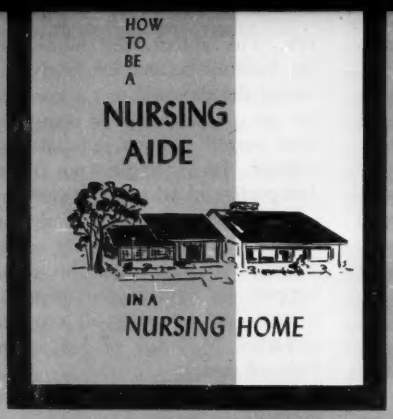
There are other reasons for noticing the concern in the possible organic losses of the aged. First, to some degree, the affective and motivational aspects of memory loss, of so-called disorientation, and the like, pass unnoticed. Second, it seems that we observe these losses more in our older patients than we do in our younger ones as a consequence of our fixed views or stereotypes about such declining functions in the aged. We would, for example, be more willing to ascribe apparent difficulty in remembering in a younger person to inner disturbance and preoccupation that we would in an older patient. Now there *is* decline in the intellectual function of the aged and it is, of course, important to assess these changes. To the extent that intellectual losses are of significance to the patient, they may be ideally taken up in the course of therapy. It has been observed that certain aged people experience their intellectual as well as their physical changes differently. To a degree, this emphasis on decline probably also reflects in some obscure way the view of the aged about themselves.

Death and the Aged. Another concern, and possible countertransference attitude, that has been observed has had to do with the meaning of death. Several therapists indicated that one reason they would not care particularly to work with aged patients was the anxiety in connection with the notion of death. Work with one patient helped illustrate this. The author, the nurses, and the internist became extremely anxious at the prospect that a particular patient would succeed in doing away with herself through self-abuse and neglect; for example, not eating. Irrespective of whatever we attempted to do, our sense of powerlessness created considerable anxiety as well as rage. It is not that this cannot happen to patients in other age groups, but we were all especially disturbed by virtue of her seventy years of age.

Death has also carried another meaning in psychotherapeutic work with the aged. Some therapists have spoken of the fact that psychotherapy is a tremendous investment in time and therefore it seems rather pointless to try psychotherapy with an individual whose life span is limited. This argument is put so cogently at times that it almost seems at the time of the discussion to be irrelevant as to whether the patient would be accessible to help or not. From a quantitative point of view, one could observe that a sixty-five-year-old person has roughly thirteen years of life by average expectations (in the case of a woman, fourteen). But it is especially notable that the qualitative aspects of time are overlooked here. One cannot know whether one has had his best and most enjoyable years or whether they are yet to come. Put another way, one cannot know for certain whether the sixty-eight-year-old, following therapeutic work and freed from the stresses which precipitated hospital admission might not then experience some of the richest times in his life.

How to "Treat" the Aged. Still another element has been that of despair. The aged, themselves, often share the despair physicians feel about the treatability of the aged. One interesting way in which this was revealed here could be subtitled, "The Stereotypes the Old Have About the Young." It became clear that one patient was not at all certain that younger people could possibly understand her as an older person; that the differences in experiences in life were too great. Dr. Will has also brought to my attention the fact that the reciprocal stereotype may also be held; namely, that

(Continued on page 18)



Here it is!

FOR BETTER TRAINED AIDES
FOR BETTER PATIENT CARE

HOW TO BE A NURSING AIDE IN A NURSING HOME

THE FIRST MANUAL ESPECIALLY DESIGNED TO TRAIN NURSING AIDES IN NURSING HOMES

CHAPTER 3 d

HOW TO HELP A PATIENT WALK

Helping a patient walk is something that you will do frequently. We know that older people are happier and better off when they can walk around from one place to another. The halls in nursing homes often have handrails to give patients support when they walk. Handrails also help prevent accidents.

The charge nurse will tell you which patients are allowed to walk. The practice place is usually in the hall or a room which is set aside for this activity.

Bed exercises help the patient get ready for walking. For example: have the patient stretch his legs, bend his knees, stretch, bend, etc., for five minutes four times a day. It takes lots of time and patience with an older person to help him walk. Progress is gradual — from sitting to standing to walking may take several months. Here are some things to remember when you are helping a patient to walk.

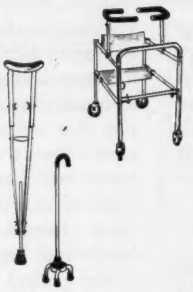
WHAT TO DO:

1. Find out from the charge nurse what kind of activity and how much of it the patient can have.
2. Tell the patient what the general plan of activity is.
3. Have the patient sit up on the edge of the bed with his feet on the chair, if he is not in the habit of getting up.
4. Have the patient put on his clothes, stockings, and shoes. Help him if necessary.
5. Help the patient into the wheelchair.
6. Take the patient to the practice place. Do not leave him alone. Usually one person stays with those who are practicing.

a. PARALLEL BARS are used to help patients stand and walk as the picture shows you. The hand rails can be changed from lower to higher levels and vice versa, depending on the height of the patient.

TELL THE PATIENT TO: Step forward with the right foot and move the left hand forward along the bar. Then step forward with the left foot and move the right hand along the bar.

Repeat several times until the patient is tired.



b. WALKERS are also used for patients who are learning to walk again. The charge nurse will show you how to have the patient use the walker.

c. CRUTCHES OR A CANE may be used by the patient after he learns to walk. They should have rubber caps on the tips for safety's sake.

7. Let the patient practice for the proper length of time. If he becomes tired, a little rest in the chair will help.
8. Take the patient to his room. He can practice walking by holding on to the foot of his bed.

HOW WELL DID I DO?

DID I:

1. Ask the charge nurse what kind and how much activity the patient should have?
2. Tell the patient the plan of activity?
3. Have the patient practice sitting up on the edge of the bed?
4. Have the patient put on his clothes, stockings, and shoes?
5. Help the patient get into the wheelchair?
6. Take the patient to the practice place?
7. Have someone stay with the patient during the practice period?
8. Let the patient practice for the proper length of time?

This manual is for aides in nursing homes. Clearly written and fully illustrated, it tells the aides how to perform simple nursing procedures required in the care of nursing home patients.

"How to be a Nursing Aide in a Nursing Home" was written by the Division of Nursing Resources, Public Health Service, Department of Health, Education and Welfare, in cooperation with the Educational Committee, American Nursing Home Association. It is being published by the Association.

Two years of study and consultation with nursing home administrators all over the country have gone into the preparation of this teaching tool. Sample lessons were tested with nursing home aides in Virginia and other places. Aides who participated in the test said: "The lessons were very helpful," "I learned something in every one of them." An administrator commented, "This is just what we need for our aides."

The introduction gives the aide special pointers on appearance, health, and conduct. Each lesson consists of three parts – a brief introduction, the main part telling "What to Do" and a series of questions entitled, "How Well Did I Do"? The emphasis is on the new approach of helping patients achieve self-care in activities of daily living.

There are 62 lessons including:

- How to make a bed
- How to help with food service
- How to help a patient into a chair
- How to help with a bed bath
- How to care for the hands and fingernails
- How to shampoo the hair
- How to help a patient dress and undress
- How to use a foot rest
- How to admit and discharge a patient
- How to care for equipment
- How to take temperature, pulse, and respiration
- How to prevent bedsores
- How to care for an incontinent patient
- How to care for a critically ill patient

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Are You Listening?

Here are ten good reasons why you should . . .

We are reprinting this article from Light, published by the Illinois Nursing Home Association. Administrators have to listen — to patients and employees. It isn't always an easy task, but listening, in fact, is an important function of their work. So — listen!

FIRST, listening is a means of understanding people better. Your success depends upon your employees and what they do. They want personal recognition and consideration — a few minutes devoted to listening can open up a whole new field of mutual relationships.

SECOND, listening is a means of giving individual recognition — failure to listen leaves the employee with a feeling that you have no interest in him and his ideas regardless of their merit.

THIRD, listening is a means of finding out what the employee wants to know or tell. A good administrator is constantly in search of new ideas. Who knows better than those doing the job what might be done to improve methods and procedures?

FOURTH, listening is a means of "sensing" trouble before it starts. It is a means of finding out "gripes" and points of dissatisfaction before they reach proportions which may lead to serious problems. It is easier to "put things straight" with an individual employee than to solve the same problems with a larger group after the grapevine has magnified something out of proportion.

FIFTH, listening is a means of making an employee feel significant. This is more than making him feel recognized. If what he has suggested constructively is adopted it still further inflates his ego. He is entitled to know the reaction to any constructive suggestion, if it will be considered and if not, why not.

SIXTH, listening is a means of "getting the feel" of your business. Maybe you cannot afford to spend all your time among employees but you might be surprised what an occasional visit among them may reveal.

SEVENTH, listening is essential to ultimate harmonious relations. What you learn from listening to your employees will enable you better to understand their problems, your problems, and indicate measures to be taken, when necessary, to improve your business. Your interest will pay off in greater responsibility on your employees part and better understanding.

EIGHTH, listening is a means of improving morale. Good relations mean good morale. Good morale means satisfied and happy workers. The work of the individual becomes a part of the whole objective rather than a task to be performed without meaning. Three workers constructing a building were asked: "What are you doing?" The first answered, "I am laying bricks for $20 per day." The second replied, "I am earning a living for my family." The third replied, "I am helping to build a great cathedral."

NINTH, listening is a means of improving production. It enables you to know and do the things which will encourage employees to greater effort.

TENTH, listening will make a better administrator of you. If you are afraid to learn what others are thinking by listening to their voices, maybe you had better have a conference with the man or woman in the mirror and listen to that "still small voice." An administrator will be faced with irascible and unchangeable employees, discouragements, frustrations, and many more difficulties. It is suggested that after trying a number of methods to establish effective working relations that he should go back and try playing it by ear.

FRANKLY SPEAKING (Continued from page 3)

object after careful consideration, and quite another to persistently object as a matter of personal philosophy. Again, 'get yourself another prospect!'

"The Free Rider, in my opinion and from my experience, is not a hopeless case. Usually, like the unfortunate maiden in the old melodrama, he is 'more to be pitied than censured.'

"Approached with a rational, unemotional, objective point-of-view, selling the Free Rider, if you really want him, is no great problem. In fact, the problem is his, not yours! With the economy leaving the small and even big, business man no alternative except 'join your peers or disappear,' yours is a job of education as well as persuasion. But, it is a worth-while job, and, when well done, one that yields countless rewards and satisfactions. Converting the Free Rider doesn't cost — **it pays!"**

We hope the foregoing, although summarized from a rather lengthy article, will give everyone concerned with the newly inaugurated membership campaign food for thought and tools to work with.

Respectfully yours,

Frank C. Bateman

Executive Director

CAPITOL

1961 is here and with it we present a few Washington forecasts of what you can expect in business, in sales, prices and profits. The trends and figures presented reflect the thinking of top government economists.

In a nutshell: It's not going to be a happy year for many businessmen. The experts don't see a serious slump — just a **mild slide** in the first half. Then, after mid-year, the easing will give way to some moderate improvement. Net, industrial output and total sales will come near this year's levels.

Things won't be really bad . . . but they won't be very satisfying, either.

Some experts prefer neutral labels for what they predict for next year. They think that "high plateau" or "sidewise movement" are more appropriate. But others feel the term "recession" gives a better picture of the outlook. They see unemployment . . . sluggish sales . . . and spotty profits as 1961's themes.

What bothers officials most is this: There'll be **no growth,** over-all.

Plus and minus forces are nearly balanced today . . . an unusual occurrence. Here's how the **key determinents of business** trend stack up:

On the side of strength, the big plus will be spending by government. States and localities will keep up the steady rise in outlays of past years. But **federal expenditures** — which fell for a while — have now turned up, too.

On the side of softness, there'll be declines in **business investment** — in inventories and in new plant capacity . . . very powerful economic forces. Also, consumers seem to be going slow on their buying . . . especially durables.

What's ahead is a period of doldrum, rather than a clear-cut downswing.

Consumers aren't putting their income increases into spending, either. Again, their needs are less pressing. And many want new, lower-cost items.

Businessmen now have so much capacity that failure of sales to climb is alone enough to prompt many companies to trim projected spending plans.

It's not that the economy has reached maturity . . . a fear of the 30's. But we're experiencing a breather before the surge of the Sixties begins. Before long, **population growth** — and new products — will spark new expansion.

The curve of business in 1961, quarter by quarter, will look like this:

January-March — Total output of goods and services will decline a little. Drops in **building,** investment, and exports will offset rising U. S. outlays.

April-June — **Business activity** will fall a bit more. Consumer cutbacks . . . mainly for durables . . . will add to cuts in inventory and plant building.

July-September — Next Summer will bring the beginnings of the **recovery.** Consumers will provide the spark; they'll run out of goods and have to buy. Inventory liquidation will slow; business will start to invest a bit more.

October-December — The recovery will continue on an even broader front. Sales of durables will perk up. Business will start adding to **inventories.**

Averaging the year out; The figures for 1961 will be close to 1960's.

These trends are not presented in a manner to alarm you but rather to alert you to the thinking of our top economists with respect to 1961. In evaluating these figures and these comments, you may want to change your plans for the coming year and develop your **expansion** for your facilities early in the year or later as the economic trend commences to rise.

Keep in mind that at low ebb you will be able to buy labor, materials and other merchandise at a lower figure than when the economy is on the rise. Gear your **purchases** to the soft money.

ECHOES

A Health Department gives some hints on...

How to Pick a Nursing Home

You may or may not agree with the advice rendered by the Garvin County, Oklahoma, Health Department on how to pick a nursing home. But, as reported in the Pauls Valley, Oklahoma, Democrat, recently, it makes important reading for administrators — and for many fellow citizens bewildered by the responsibility of placing loved ones into someone else's care.

The Garvin County, (Oklahoma) health department recently issued a statement urging care and advance inspection, along with a number of tips, on selecting a nursing home for elderly relatives.

The statement follows:

"In the past few weeks your health department has had numerous inquiries in regards to nursing and rest homes for our senior citizens.

"Not too many years ago the elderly citizens were taken care of by their families. The trend today is toward mass care of older persons. The care of our senior citizens has become one of the largest growing businesses in Oklahoma. Today we have nursing and rest homes in most of the towns and cities in Oklahoma.

"A few years ago the state legislature gave the health department of Oklahoma the responsibility of supervising nursing and rest homes in Oklahoma. County health nurses and sanitarians avail themselves to the nursing and rest homes for consultant services. We found that in Oklahoma we had a number of good establishments but we also found a number that were not so good. Since that time we have been in the process of upgrading these homes, weeding out undesirable ones until today, in most of our homes in Oklahoma, the facilities and care are good.

"If you are thinking of selecting a home for one of your loved ones, the first rule to follow is to select one close to relatives or friends where they can be visited fairly often.

"Visit the home, after you have one in mind. While there, you should ask about fire protection, notice other safety measures such as hand rails, well lighted halls, absence of throw rugs, look at kitchen and bath rooms.

Are the rooms crowded? Is the living room area used? Notice the appearance of the patients. Are they happy, clean and interested in their surroundings: Are patients permitted to have personal belongings with them?

"Have a frank discussion with the operator as to the cost of care in the home. Ask about medical care policy of the home. You can expect a reasonable amount of patient care, but home rates do not permit the amount of skilled nursing care given in hospitals. Discuss meals and menus. Have the help had any type of training? Are employees neat, kind and patient? Do they reflect interest in their patients? Do they encourage the patient to improve physically, mentally and socially?

"After placing a loved one in a home, frequent visits by the relatives and friends, cards and letters help to pass the time. Inform the pastor of the new address. If the home is in another town, he can make arrangements for a clergyman of like faith to call on them. Above all, remember when you place a loved one in a nursing or rest home, you are not sending them off some place to die . . . but to live. So it is up to you to help the employees of that caused by defective heating equipstill have an interest in life."

ARE YOU READY FOR WINTER?

The winter season is with us, and with its arrival may come problems. Some nursing homes had to cope with prolonged interruption of telephone service, electric power supply, water supply, heating, transportation and the like. These conditions could happen again. This would be a good time to start thinking about the matter and for making preparations to cope with such problems should they arise this winter.

Food Service: Part of Total Care

By Phoebe Fowler

Supervisor, Nursing Home Services
Hospital Division
Oklahoma State Dept. of Health

Group care for the elderly requires some insight into their needs and behaviors. Perhaps in no other area is behavior more revealing than in the significant ways in the intimate associations of their eating habits. Behavior of the elderly may be stronger and more set than even of a child. Perhaps as we exchange thoughts and experiences about your patients we may learn greater tolerance for and understanding of disturbances about the food service.

It is true that a great deal of your time, the patient's time, and a large percentage of your total cost is invested in the feeding situation.

When you cook for more than a few persons you soon have a group feeding situation — persons eating together, persons from different backgrounds who may have never known one another before. Fear and anxiety will exist in this new and unfamiliar situation. The very common problem of loss of appetite occurs. Anxiety and depression are of great importance and affect appetite directly. Anger exists with this fear and anxiety. *In the elderly, rage and disappointment, from whatever source, are often reflected in food refusal.*

Isolation and withdrawal experienced by many persons in old age is often associated with a reduction of food intake.

In the aged, disturbances in appetite are sensitive indicators of anxiety. Often, the first clinical evidence of more serious emotional disturbances is seen during the feeding situation.

Food prejudices and aversions are often kept intact throughout life. Practically all food dislikes originated during an intense emotional situation. Old age will not eliminate any food dislikes but further food dislikes can be developed.

Persons who keep strict habits and insist upon them may have a need to deny themselves, punish them-

selves, or they may be very rigid persons who find a security in the ritual of adhering to a strict, set pattern. It could be a struggle going on in them between defiance and compliance to authority figures.

What can you do? Organization, visit with patients, planning and freedom of choice can mean being cared for without compliance or fitting in being demanded. Making decisions, opportunity to express self.

Special diets and modified diets usually carry a feeling of special privileges, others may be jealous of this attention as children are jealous, or competitive as brothers and sisters. Change of surroundings or regression or going backwards in illness, behavior becomes more child-like. There is a stronge tendency for them to look for and need protective care and to seek a parental figure.

You can become this figure and help the patient accept the food and surroundings.

By becoming more aware of the emotional significance of food, you can see the demands of your patients in wanting particular foods or refusing others. Not so much as whims or fancies but rather as needs growing out of attempts to deal with anxiety. By knowing this, you should expand and increase your policies toward more individual dietary considerations. And remember: "reason" almost never determines eating behavior.

Important notes to remember — Choice of beverage, vegetable, dessert; planning; have adequate equipment; holiday meals, Valentine, Halloween, 4th, George Washington, Lincoln, May Day, etc.

Be a hostess to your guests. It is not *how* your dining room is but *what* it is.

(*Reprinted from: Oklahoma Nursing Home News*).

STUDY INDICATES SOME FATS DO NOT GUM UP BLOOD

A study recently concluded indicates some fats do not increase the viscosity of the blood, a factor implicated in the development of blood clots which cause heart attacks and strokes.

Some investigators have suggested that a high level of fats in the bloodstream might be a factor in the development of blood clots by increasing the adhesiveness of red blood cells, slowing the circulation and increasing blood viscosity. Earlier experiments with dogs and hamsters indicated that intravenous administration of fats did increase the viscosity of the blood, i.e., made it more sticky and gummy.

However, a study by Drs. Martin A. Shearn and Aristides Gousios, Oakland, Calif., reported in a recent issue of Archives of Internal Medicine, published by the American Medical Association, indicates that this may not hold true in human beings. Their study involved 13 human subjects in whom fats also were administered by injection.

"The blood lipid [fat] levels increased in each experiment, reaching in some instances a threefold increase," they reported. "In spite of the magnitude of this rise in total lipids, there was no significant change in the viscosity of the blood."

The authors said their study differed from the animal studies because their method reflected the viscosity of the blood in medium-size vessels, where most blood clots occur in man, while the other studies reflected the viscosity in the small blood vessels.

"In view of conflicting reports regarding the role of cholesterol and other fats on blood viscosity, studies are in progress to determine whether ingested fats or combinations of intravenously administered lipids other than that used in the present study cause a change in blood viscosity," they added.

The authors are associated with the department of medicine, Permanente Medical Group, Kaiser Foundation Hospital.

LEADERSHIP

The question of leadership is an interesting one in the day of the organization man. Obviously, leaders must have gotten out of step with their colleagues at some point or they would not be out in front . . . Company executives might keep an eye out for men whose left foot is forward while the rest of the ranks, have their right foot out . . . they might have different ideas on how the company should march. And that's what companies need — different ideas.

What I Saw in Europe

(Continued from page 7)

but here, as in Yugoslavia, the community takes no interest in the program.

Rates for patient care vary in different homes and institutions. The government institution rates are lowest, averaging about 16c per day. The home and institutions operated by religious orders show an average of patient rates ranging from $1.36 to $2.00 per day. Proprietary homes charge from $1.75 per day to $80.00 per month.

Average salaries in Italy for nursing home work are good by most European standards. The registered nurses, members of religious orders, receive room and board only as their services are donated on behalf of the church they represent. Practical nurses with training receive $96.00 per month and nursing aides, domestics, laundry and kitchen helpers are paid $64.00 per month.

SWITZERLAND

Switzerland compares more closely with our nursing home standards and procedures than other countries on the European continent. Here I visited a very modern nursing home, Adullam-Stiftung Basel, in Basel, which has a capacity of 155 beds, all of which are occupied.

Mr. Ernest Gilgen is the administrator of this home which was started by his father. Mr. Gilgen, since becoming administrator, has changed his operational procedure from proprietary to non-profit and the city of Basel has increased its interest in the home. Donations to the home have enabled Mr. Gilgen to construct a $900,000 building which is the most modern home of its kind in Switzerland.

How it Operates. Adullam-Stiftung Basel is not hospital-associated and is licensed by the Health Department through the state. All types of patients are accepted into the home — the only stipulation being that they are citizens of Basel. The average patient age is about 70 years.

Adullam-Stiftung Basel has a medical care program which provides a house physician for the chronically ill and bed-ridden patient. Ambulatory patients are free to acquire services from their personal physicians. The home offers very good special nursing care as well as general care and the staff consists of 7 registered nurses, 5 practical nurses, 10 aides, 2 cooks and 6 kitchen helpers. Special diets are offered and all food buying is done by the Gilgen family. The grounds are quite extensive and require the care of 7 men who also serve as the home's maintenance crew. The laundry employs 6 workers, there are 2 physical therapists, 2 laboratory technicians, 1 house mother, and 3 girls who do nothing but wash dishes.

The average number of hours of nursing care is seven. During this 7 hour period all daily nursing procedures are taken care of with the exception, of course, of special routines which require 24-hour supervision.

The nursing personnel receive their training at hospitals and nursing schools. The nursing aides receive their training at hospitals and in the home itself. All special nursing services are offered, including X-ray.

The home offers recreation programs and provides special rooms and equipment for the purpose of entertainment. Rehabilitation programs are followed, special bathing facilities for therapeutic treatment are available and diathermy is offered. Physical therapy is under the direction of specially trained personnel.

Laundry service is provided by the home and the equipment is modern and of commercial size and quality.

Records are kept on all procedures and drugs are controlled and administered by the registered nurses, under direct supervision of the house physician.

The building has been expanded from a 30 bed home which has been remodeled to conform to the new addition which houses 125 beds. Maintenance is excellent and safety measures are strictly adherred to.

The home provides private and semi-private rooms as well as wards and its relationship with doctors, hospitals and the community in general is exceptionally good.

Rates for patient care: Ambulatory patients, $2.35 to $3.75 per day for private rooms. Bed patients, $3.05 to $5.85 per day for private rooms. Semi-private rooms cost $4.20 per day. Four bed wards cost $3.05 per day per patient. Slight extra charges are made for use of telephone, radio, laundry, physical therapy, laboratory work, and tray service in rooms.

Out of a total of 155 patients only 16 patients are unable to pay for their care and are charges of the state. Most patients receive pensions or special government funds to supplement the rates charged by the home.

Throughout Switzerland there are 2 or 3 non-profit homes in each county or district. There is a total of 5 government institutions in Switzerland but no proprietary homes are operating now. There is a national hospital association in Switzerland and only one nursing home is licensed.

ENGLAND

England has an extensive program for the care of the chronically ill and aged. The country's social medicine policy influences the type of home found in England.

Stewart Lodge in London, a 56 bed non-profit government home is licensed by the Public Health Department. This home accepts ambulatory and wheel chair cases only and the average patient's age is 80 years.

The head nurse and administrator of Stewart Lodge, Miss Pearl Rawbotham, told me that, although patients in the home could use the services of the house physician, they were also free to consult with any physician of their choice.

The type of nursing service available at Stewart Lodge is general only. The staff consists of a house physician, a registered nurse, a practical nurse, 5 nursing aides, a cook, 4 domestics, and a maintenance man. Special nursing services available are intramuscular injections and sterilization only.

Miss Rawbotham is in charge of all food purchasing, preparation and serving of special diets. Her work is directly supervised by the Health Department.

Recreation and entertainment at Stewart Lodge is provided for by civic and church groups in addition to the usual past-time of reading and watching television. Occupation-

al therapy is provided by the home's personnel staff and physical therapy is available through the co-operation of the local hospital.

Laundry and dry-cleaning service is provided in English nursing homes at no additional charge to the patient.

Charting on all nursing procedures is extensive and records are kept up on admittance, diagnosis, prognosis, discharge, deaths, and drugs. Drugs are under strict control and administration.

Stewart Lodge is a new building, its maintenance is good and safety procedures are excellent. The home offers private and semi-private rooms and 5-bed wards. The relationship of the home with doctors, hospitals and the community is considered good.

Charges for care at Stewart Lodge: $20.00 per week with medications included. Monthly salaries for the personnel are as follows: the Administrator receives $110.00 per month plus room, board, laundry, and free medical care; the practical nurse receives $20.00 for a 44-hour week; domestics average $19.00 and maintenance men average $23.00 USC per week.

All nursing homes in England are filled to capacity. All private nursing homes must be registered with the local health authorities and their charges average about $50.00 per week. Rates for nursing care in government homes average about $6.00 per week.

Relief patients in England are able to retain about $1700.00 in savings plus any property or real estate in their possession at time of application for aid.

What It All Taught Me

My tour through nursing homes was enlightening and interesting to me. I returned with many new ideas on the planning and operation of nursing homes, and interior decoration for the public and private rooms for nursing home patients. I found that many of the European administrators have the same *ideas* and *ideals* in mind that administrators of nursing homes in this country have. But some of them face quite a struggle ahead to meet or even come near our standards of operation and achievement.

A Psychiatrist Looks At The Nursing Home

By Henry Veit, M.D.

A recent issue of Silver Threads, monthly publication of the Wisconsin Association of Nursing Homes, carried the provocative article below. Because of its universal interest to our profession, we are reprinting it here:

From the standpoint of a psychiatrist, I was asked to present a viewpoint on the present facilities, care and treatment available, and the future of the nursing home. The U.S. Public Health Service reports that available homes for the aged are below even the basic number required. Hence, legislation has been passed to increase the number of beds available. Insurance statistics report that the need can only increase with the population trend toward an increased span of life.

When legislation for convalescent homes by the State of Wisconsin was considered, the admission and care of psychotic cases was questioned. However, upon close scrutiny of patients already being cared for, it was noted that many could be readily classified as psychotic. These were mentally infirm on the basis of senility, arteriosclerosis, presenile processes or chronic brain syndrome, psychotic reactions, due to any number of causative factors such as circulatory deficits, nutritional, metabolic, and psychogenic. That these were not declared legally insane and committed as such was due only to the consideration and tolerance of their relatives and the convalescent home personnel.

Many Former Patients

It must be noted that a number of patients, who previously were at mental hospitals and released as improved, with adjustment difficulties increasing due to age, found supportive shelter and necessary supervision and support in the home. Actually temporary disturbed periods in the home appear to be accepted by other patients, if the stay has been long enough to be accepted into their "family home unit." In situations of this type, not only the time-tested sedatives, but tranquilizers or the ataractic drugs are most useful in ameliorating these periods.

It is well documented in psychiatric hospitals, that oral or intramuscular thorazine—sparine, as well as the other phenothiazine drugs make it possible to quiet down quickly and control otherwise locked ward patients. These patients in the past required restraints, but these measures are seldom used with the modern "chemical restraints," the tranquillizers. Darkness for many insecure disturbed individuals is a more difficult period of the day; so adequate dosage per individual requirements is necessary.

Practical Way Best

Practical daily psychiatry — how to live with, influence, and maintain good will — is an important factor in a convalescent home. For the paranoid patient — that one who is constantly critical, feels persecuted, and tends to foment difficulties — a routine pattern of daily living with no close relationships is best. For the one who is forgetful — a notebook of daily events recorded is helpful. For the one who claims to hear voices and sees things that aren't there, just listen and be noncommittal. General rules and regulations posted and understood by all i.e., what is bed-time, procedure to check out for a few hours et al. makes for less explaining to patients, relatives, and friends.

Actually, the less said the better usually. If the patient cannot adapt to the home, then the patient and the family should be advised that the home does not appear to be able to serve him best and recommend trying another with different facilities.

It is my belief that more and more patients from county and state institutions will be released to be cared for in the convalescent homes. In a broad sense, they constitute a "half way house" between the hospital and the home. Where supervision, medication, and general 24 hour care is needed, no other facility can presently replace them.

Dr. Veit has a private practice in Milwaukee. In addition, he is a clinical instructor in psychiatry at Marquette University; a psychiatrist to Milwaukee county hospitals and institutions and a staff member at several Milwaukee private hospitals.

Re-Awakening Interests

(Continued from page 9)

the young may feel that the old have never understood and are, in fact, "beyond understanding."

The protective attitudes easily developed toward the aged person (undoubtedly reflecting our culture as well as our personal anxiety) have already been alluded to. Denial is often reinforced by way of withholding unpleasantries, by way of reassurance, helping the patient to make a decision, and the like. One does not, thereby, affirm the capacities of the aged but concurs with their sense of recline. Inherent also is the idea that too much insight is dangerous, and that the aged are peculiar in that they cannot "stand the truth." The aged, in turn, as indicated before, may utilize age defensively becoming increasingly helpless and enraged.

Akin is the idea of respect for the older person. Of course respect is important for the aged person as it is for the younger person, *but there can be something disrespectful and distancing about respect.* In short, care need be taken that respect is not a maneuver on the part of the therapist to alleviate his own anxieties about closeness to the aged patient.

The Past Remembered. Earlier I mentioned the difficulty we experience in *listening* to the older person. Since the forming of a relationship and individualization are especially important in maintaining as well as reactivating interests, I would like to offer one explanation for the garrulity and reminiscense of the aged. I believe that recognition of the occurrence of an inner process, a life-review, may help us to understand, to tolerate and to listen.

The life review is an inner experience or process which I have come to believe occurs in all persons' final days of life, although they may not always be totally aware of it and may, in part, defend themselves from realizing it. My assumption is that this process of reviewing one's life is to a major degree prompted first of all by the realization of approaching death and, secondly, by the realization that one's personal myth of invulnerability can no longer be maintained.

We may see the life review in mild form in terms of increased

likelihood of reminiscence, mild nostalgia, mild regret, story telling, and the like. We may note that older people have a particularly vivid imagination about the past and can recall with sudden and remarkable clarity early life events. I think this process is often normative and often constructive, for I believe that change can occur at any age, including old age. I think that this process often involves reintegration in one's personality based on a re-evaluation of one's life experience.

This may relate to the recent comment of W. Somerset Maugham, "What makes old age hard to bear is not the failing of one's faculties, mental and physical, but the burden of one's memory." Thus, in some ways the life review of the older person may be similar to the psychotherapeutic situation in which a person is reviewing his life in order to understand his present. However, there is a least one significant difference — the life review in the older person may be conducted in monologue without the opportunity of another person hearing, commenting, relating to and with the reviewer.

From time to time in the course of the life review, the reviewer's sense of regret may become increasingly painful. He may experience some considerable anxiety, despair and depression when he thinks about things of the past. He may consider, for example, what he would like to have been and did not become, or things that he would like to have done which he did not do, etc. At times the reviewer's environment and the people about him do not respond too kindly to his behavior, mood states, and tendency to reminisce. At times, then, the older person is referred to as "living in the past," behind the times," as being garrulous, as *boring*. If the individual becomes increasingly isolated in the process of his life's review, then I think he frequently experiences severe immobilizing depression which may relate to the increasing frequency of suicide which occurs with increasing age.

Summing Up

I have tried to indicate some general principles for use in our work with the aged patient — in our attempt to *collaborate with him* in re-awakening interests. I have emphasized that the older person must himself contribute to the activation process and that he can more often than we realize. His tendency to accept the helpless dependent position must be avoided. Age itself can be used as a defense and we may unfortunately collaborate with him in this defense. There are also certain personal or countertransference attitudes which are identifiable which do not favor activation or insight, such as emphasis upon cognitive decline and concern about death. Moreover, the tendency of reminiscence and garrulity may create states of irritation and boredom within us, the observer, but if we can recognize the potential value of the older person's communication, and his drive to communicate his life experiences (i.e., his life review), we may find it more possible to understand and to listen. It is important to listen for ultimately forming a relationship and individualization are the basic ingredients necessary to the re-awakening of interests. Finally, it should be emphasized that we know a great deal more than is ordinarily applied in our work with the aged.

State Associations Directory

Alabama Nursing Homes Association
President: Garland L. Rollins, P.O. Box 305, Falkville. Secretary: Mrs. J. H. Kelly, P.O. Box 88, Haleyville. Treasurer: Robert V. Santini, Route 12, Box 158, Birmingham. A.N.H.A. Governing Council Member: Garland L. Rollins.

Arizona Association of Nursing Homes
President: Pauline Williams, 1608 E. Meadowbrook, Phoenix. Secretary: Ione A. Dockstader, 6825 North 16th St., Phoenix. Treasurer: Loren Hauschild, 2211 E. Southern Ave., Phoenix. A.N.H.A. Governing Council Member: Pauline Williams.

Arkansas Nursing Home Association
President: Mrs. Mason Comer, 604 North 4th Street, Lonoke. Secretary: Jackie Kilgore, Carraway. Treasurer: Mrs. S. Rowe Grible, 923 David O'Dodd, Little Rock. A.N.H.A. Governing Council Member: Ruth Richardson, 619 Center, Conway.

California Association of Nursing Homes, Sanitariums, Rest Homes and Homes for the Aged, Inc.
President: Mrs. Marion Gellmann, 924 Balboa St., San Francisco. Secretary: Cliff Fairfax, Box 251, San Carlos. Treasurer: Birre Gipe, 541 North Fulton, Fresno. A.N.H.A. Governing Council Member: Mrs. Gellmann.

Colorado Nursing Home Association
President: H. Virgil Davis, 1427 Gaylord, Denver. Secretary: Dorothy Cording, Route 1, Eldorado Springs Road, Boulder. Treasurer: Vesta Bowden, 1455 Beeler Street, Aurora. A.N.H.A. Governing Council Member: H. Virgil Davis.

The Connecticut Chronic and Convalescent Hospital Association, Inc.
President: Theodore E. Hawkins, 1768 Whitney Ave., New Haven. Secretary: Vera Arterburn, 267 Union Ave., West Haven. Treasurer: Leander Lavigne, 157 Hillside Ave., Waterbury. A.N.H.A. Governing Council Member: Mrs. Robert Baird, North Star Route, New Milford.

Delaware Association of Nursing Homes
President: Alice Ulmer, 160 Winston Avenue, Elmhurst, Wilmington 4. Secretary: Blanche Williams, Clarksville. Treasurer: Paul J. Turek, 1506 North Broom Street, Wilmington 6. A.N.H.A. Governing Council Member: Alice Ulmer.

Florida Nursing Home Association
President: Ernest Ripley, 1711 6th Ave., S., Lake Worth. Secretary: Ann Tompkins, 1006 West Main St., Leesburg. Treasurer: Frank Cuyler, 504 3rd Ave., South, Lake Worth. A.N.H.A. Governing Council Member: Ernest Ripley.

The Georgia Association of Nursing Homes and Homes for the Aged
President: Thomas E. Anthony, 2725 Vineville Avenue, Macon. Secretary: William M. Crane, 663 North Milledge Street, Athens. Treasurer: Louis Newmark, 260 14th Street, N. W., Atlanta 13. A.N.H.A. Governing Council Member: Thomas E. Anthony.

Idaho Nursing Home Association, Inc.
President: Joseph Kempf, 3115 Sycamore Drive, Boise. Secretary-Treasurer: Anna Frint, 603 E. Main St., Emmett. A.N.H.A. Governing Council Member: Joseph Kempf.

Illinois Nursing Home Association
President: Margaret Setzekorn, 1300 Broadway, Mt. Vernon. Secretary: Jeannette Kramer, 417 North Kenilworth, Oak Park. Treasurer: Helen Nelson, 205 North Main, Saybrook. A.N.H.A. Governing Council Member: Margaret Setzekorn.

Indiana Association of Licensed Nursing Homes
President: Margaret L. Nickols, 812 Riverside Avenue, Muncie. Secretary: Marjorie M. Fordyce, 321 North Morgan Street, Rushville. Treasurer: Emory H. Vollmer, 2630 North College Avenue, Indianapolis. A.N.H.A. Governing Council Member: Marjorie Pearsey, 114 East Fifth Street, Rushville.

Iowa Nursing Home Association
President: Charles B. Shindler, 1211 Pleasant Street, Des Moines. Secretary: C. B. Verdoorn, Ashton. Treasurer: W. S. Bauman, 222 North 18th Street, Clarinda. A.N.H.A. Governing Council Member: Charles B. Shindler.

Kansas Nursing Home Association, Inc.
President: L. V. Biffer, Jr., P. O. Box 812, Wichita. Secretary: Viola Wagner, 301 West First, Washington. Treasurer: Robert E. Truitt, 525 East Second Street, Tonganoxie. A.N.H.A. Governing Council Member: Louisa Joplin, Box 632, McLouth.

Kentucky Association of Nursing Homes
President: Elizabeth Perry Baxter, 2725 Virginia Avenue, Louisville 11. Secretary: Ann Stokes Ralph, 105 Lyndon Lane, Lyndon. Treasurer: Bernice Sisk, 641 park Avenue, Madisonville. A.N.H.A. Governing Council Member: Elizabeth Perry Baxter.

Louisiana Association of Licensed Nursing Homes, Inc.
President: Emily Averitte, 816 Nashville Avenue, New Orleans. Secretary:: Natalie White, Rt. No. 1, Box 1310, Lake Charles. Treasurer: L. G. Van Mullen, 6100 Chef Menteur Highway, New Orleans. A.N.H.A. Governing Council Member: Carmen Lindig, 6271 Boone Avenue, Baton Rouge.

The Maine Association of Nursing Homes
President: Kenneth Robinson, 284 Brunswick Avenue, Gardiner. Secretary: Alzada Simmons, Western Avenue, Winthrop. Treasurer: Roy Meister, 25 Court Street, Belfast. A.N.H.A. Governing Council Member: Kenneth Robinson.

Maryland Nursing Home Association
President: Eugene J. Lipitz, 16 Fusting Avenue, Cantonsville 28. Secretary-Treasurer: H. L. Fahrney, M. D., Jefferson Boulevard, Braddock Heights. A.N.H.A. Governing Council Member: Eugene J. Lipitz.

Massachusetts Federation of Nursing Homes
President: Frithiof B. Carlson, 44 Old Upton Road, Grafton. Secretary: Ruth Pope, 140 Webb Street. Weymouth. Treasurer: Sydney Nathans, 180 Beauchamp Terrace, Chicopee Falls. A.N.H.A. Governing Council Member: Morrill Stone Ring, R.N., 26 Ridgewood Terrace, Springfield.

Michigan Nursing Home Association:
President: Ila Arthur, 515 Lyon St., N. E., Grand Rapids. Secretary: Dr. Robert Cotton, 9230 Ann Arbor, Rt. No. 2, Grass Lake. Treasurer Emmett Calhoun, 1404 W. Territorial Rd., Battle Creek. A. N. H. A. Governing Council Member. Ila Arthur.

The Minnesota Nursing Home Association
President: Sidney S. Shields, 209 Security Building, University at Raymond, St. Paul 14. Secretary: Naime Wessin, 725 Fremont Avenue, North, Minneapolis. Treasurer: Raymond C. Olson, 400 10th Avenue, N. W., Austin. A.N.H.A. Governing Council Member: Karl T. Spellum, Lester Prairie.

Mississippi Nursing Home Association
President: Harry D. Helman, 1004 North St., Jackson. Secretary: Ilda M. Hudnall, R.N., 1220 24th Ave., Meridian. Treasurer: Oresa Fowler, Eupora. A.N.H.A. Governing Council Member: Harry D. Helman.

Missouri Association of Licensed Nursing Homes
President: B. R. Horton, 1310 E. Armour Blvd., Kansas City. Secretary: Kay Lindeman, 3537 Main St., Kansas City. Treasurer: Elmo Newberry, 3215 Campbell, Kansas City. A.N.H.A. Governing Council Member: B. R. Horton.

Montana Nursing Home Association
President: Mary Sande, Box 156, Box Elder. Secretary: Nellie Cornelius, 208 South 35th St., Billings. Treasurer: Joe Ronchetto, 444 W. Broadway, Butte. A.N.H.A. Governing Council Member: Oleta Willis, Box 207, Stevensville.

Nebraska Association of Nursing Home Operators
President: Ira Clark, 7915 North 30th St., Omaha. Secretary: Lillian M. Clark, 1845 D Street, Lincoln. Treasurer: Rex D. Earl, 2410 Fowler, Omaha. A.N.H.A. Governing Council Member: Ira Clark.

Nevada Nursing Home Association:
President: Leandro D. Tomaso, 1015 Spanish Springs Rd., Reno. Secretary-Treasurer: Beverly Tomaso, 1015 Spanish Springs Rd., Reno. A. N. H. A. Governing Council Member: Leandro D. Tomaso.

The New Hampshire Association Licensed Nursing Homes
President: Enos O. Brown, 90 Stark St., Dover. Secretary: Edwina V. Merrill, 221 Glenwood Ave., Franklin. Treasurer: Mary McKerley, 174 So. Main St., Concord. A.N.H.A. Governing Council Member: Enos O. Brown.

Licensed Nursing Homes Association of New Jersey, Inc.
President: George E. Conley, 82 North Main Street, Cranbury. Secretary: Leonard A. Coyle, 562 Lafayette Avenue, West Trenton. Treasurer: Jesse Wallace, 304 Teaneck Road, Teaneck. A.N.H.A. Governing Council Member: George E. Conley.

New Mexico Association of Nursing Homes, Inc.
President: Kathryn Vaskov, Rt. 1, Box 96-A, Las Cruces. Secretary-Treasurer: Olga Vaskov, Rt. 1, Box 96-A, Las Cruces. A.N.H.A. Governing Council Member: Kathryn Vaskov.

New York State Nursing Home Association, Inc.
President: Alton E. Barlow, 40 East Main St., Canton. Secretary: Anna F. Schwartz, Box 21, Minoa. Treasurer: Austin Barrett, 685 Linwood Ave., Buffalo. A.N.H.A. Governing Council Member: Anna F. Schwartz.

North Carolina Association of Nursing Homes
President: Edith Green, R.F.D. 4, New Bern. Secretary: Lina H. Padgett, 107 Walnut Street, Waynesville. Treasurer: Louise Woodall, 1005 Kenan St., Wilson. A.N.H.A. Governing Council Member: Dorothy Joyner, 2623 Crescent Ave., Extension, Charlotte.

North Dakota Association of Nursing Homes
President: Rev. R. R. Hanselman, Dickinson. Secretary: Orren Lee, Northwood. Treasurer: O. H. Hove, M. D., Minot. A.N.H.A. Governing Council Member: Mrs. Don Nash, 408 6th St., Wahpeton.

Ohio Association of Nursing Homes
President: J. C. Weaver, Jr., 2157 Glenwood, Toledo. Secretary: Eileen Turner, 2111 Jefferson, Toledo. Treasurer. Bruce Levering, R.R. 3, Fredericktown. A.N.H.A. Governing Council Member: Leo Glass, 3536 Washington Ave., Cincinnati 29.

Oklahoma State Nursing Home Association, Inc.
President: Carroll E. Young, 120 East Main St., Weatherford. Secretary: Marjorie C. Magee, 2307 S. W. 27th, Oklahoma City 8. Treasurer: George Machtolff, P.O. Box 448, Guthrie. A.N.H.A. Governing Council Member: Carroll E. Young.

Oregon Nursing Homes, Inc.
President; Herbert E. Wandtke, 1945 W. Powell Boulevard, Gresham. Secretary: Sara Strandholm, 2116 N. E. 47th, Portland. Treasurer: Ruby E. Gleason, 503 North College, Newberg. A.N.H.A. Governing Council Member: Herbert E. Wandtke.

Pennsylvania Association of Nursing and Convalescent Homes
President: Jacob I. Roe, 148 N. Charlotte Street, Lancaster. Secretary: Antoinette Swankoski, Drums. Treasurer: Catherine Fox, Warrington. A.N.H.A. Governing Council Member: Jacob I. Roe.

Rhode Island Association of Nursing Homes
President: Anne Theinert, 33 Pleasant View Avenue, Greenville. Secretary: Nettie Farrell, 26 Fourth Street, East Providence. Treasurer: Anna French, 21 Bull Street, Newport. A.N.H.A. Governing Council Member: Ralph Holmes, 1224 Narragansett Boulevard, Cranston.

South Carolina Association of Nursing Homes
President: Leora Maulden, 1434 S. Main St., Greenwood. Secretary-Treasurer: Rev. J. F. M. Hoffmeyer, Box 15, Orangeburg. A. N. H. A. Governing Council Member: Grace S. Southerland, Box 697, Myrtle Beach.

South Dakota Association of Nursing Homes
President: Mrs. Melvin Pearson, Astoria. Secretary-Treasurer: Viola Baugatz, 400 Third Avenue, Sioux Falls. A.N.H.A. Governing Council Member: Mrs. Melvin Pearson.

Tennessee Nursing Home Association
President George T. Mustin, 642 Semmes St., Memphis. Secretary: Catherine Anderson, 4005 Broadway, N.E., Knoxville. Treasurer: Blanche DeLaney, 1227 Sixteenth Ave., S., Nashville. A.N.H.A. Governing Council Member: George T. Mustin.

Texas Nursing Home Association
President: Sam McCaskill, 4303 Gaston Ave., Dallas. Secretary: Mrs. E. E. Bauerle, Box 3216, Austin. Treasurer: Mrs. Hugh V. Jones, 1723 Hemphill St., Ft. Worth. A.N.H.A. Member: Harry Reever, 4038 Lemmon Ave., Dallas.

Utah Professional Nursing Home Association, Inc.
President: Mrs. Samuella Hawkins, 1216 East 13th South, Salt Lake City. Secretary: Ednamae Gillespie, 300 South Main St., Tooele. Treasurer: Evelyn Maxwell, 331 Center St., Salt Lake City. A.N.H.A. Governing Council Member: C. Clark Bonner, 235 "A" St., Salt Lake City.

Vermont Association of Licensed Nursing Homes
President: Milton Aylward, R.F.D. 2, Waterbury. Secretary: Mrs Marion E. Zanleoni, 31 Richardson St., Barre. Treasurer: Leon Dion, 102 Pleasant St., West Rutland. A.N.H.A. Governing Council Member: Milton Aylward.

Virginia Association of Nursing Homes
President: Bernard Maslan, 2112 Monteiro Ave., Richmond. Secretary: Belle Wynkook, West Market St., Leesburg. Treasurer: C. Arthur Fowler, Route 1, Box 92, Blake Lane, Oakton. A.N.H.A. Governing Council Member: Martin Dalton, Box 746, Annadale.

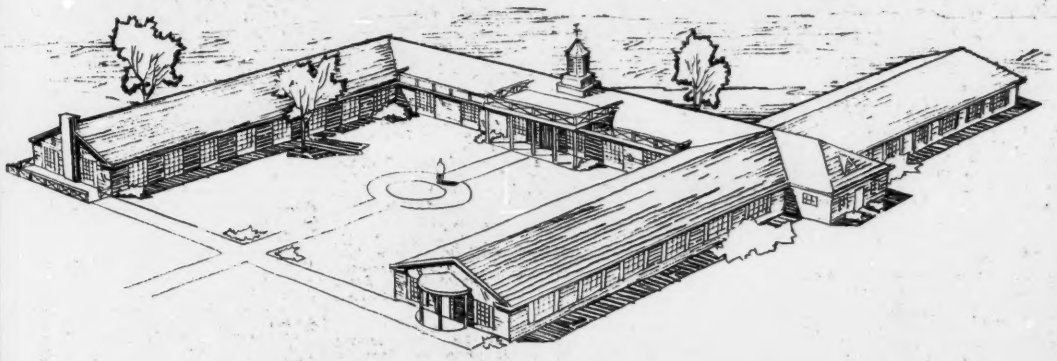
Washington State Nursing Home Association
President: Alden H. Burman, Star Route, Box 400, Tacoma. Secretary-Treasurer: Dorothy Stilwell, 723 2nd St., N. W., Puyallup. A.N.H.A. Governing Council Member: Alden H. Burman.

West Virginia Nursing Home Association
President: Daniel F. Berlin, 815 Grand Central Avenue, Vienna. Secretary: Wilma Conaway, 2312 Highland Avenue., Parkersburg. Treasurer: T. B. Gilmore, P. O. Box 3193, Huntington. A.N.H.A. Governing Council Member: Herman Conaway, Harrisville.

Wisconsin Association of Nursing Homes, Inc.
President: Elmer C. Kocovsky, M.D., 6217 West Lloyd Street, Wauwatosa. Secretary: Mary Bernikowicz, 6014 18th Ave., Kenosha. Treasurer: Eileen Wagner, 1804 N. 10th St., Monroe. A.N.H.A. Governing Council Member: Elmer C. Kocovsky, M.D.

Wyoming Association of Nursing Homes
President: Clara Jokimaki, State Park, Thermopolis. Secretary: Wilma Bigner, West C & 14 Ave., Torrington. Treasurer: Buelah Bushmaker, 244 East Works, Sheridan. A.N.H.A. Governing Council Member: Clara Jokimaki.

We Proudly announce our selection as Construction Consultants & Designers of the International Nursing Home Research, Education & Service Center, Washington, D. C.



The following eight questions are most commonly asked of us:

1. Q. — HOW DO I GET FINANCING?
   A. — Through FHA, SBA, private lending institutions and/or sale of stock in your community.
2. Q. — WHAT MAJOR MISTAKES SHOULD BE AVOIDED?
   A. — Not following a predetermined "master plan" based on the 5 major steps required to insure success.
3. Q. — WHY ARE YOUR COSTS SO LOW?
   A.— They result from efficient modular design and construction techniques combined with mass purchasing power.
4. Q. — ARE YOUR BUILDINGS PREFABRICATED?
   A. — Definitely not. Our designs meet your individual room requirements and site conditions. They allow full flexibility and individual expression as desired.
5. Q. — WHO BUILDS YOUR BUILDINGS?
   A. — Local contractors under the full time direction of our job superintendent.
6. Q. — DON'T WE HAVE TO USE A LOCAL ARCHITECT?
   A. — Not unless you want to. Our drawings meet all local and state requirements and carry the seal of a registered architect or engineer licensed in your state.
7. Q. — WHAT CAN YOU DO FOR US?
   A. — We can assist you in any one or all of the following 3 major categories of professional services:
      A. Management and Financing
      B. Architecture and Engineering
      C. Construction and Purchasing
8. Q. — WHAT IS THE COST OF YOUR SERVICES?
   A. — Actually nothing. Although our fees are comparable to similar professional services in other fields, total savings to Owners using our "Packaged Approach" exceeds such charges by 25% to 100%.

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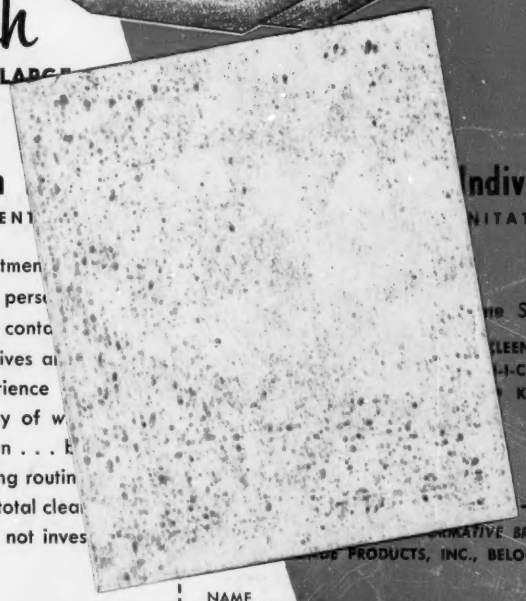

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